Children's Mental Health Block Grant
FY 2007

CRITERION 1: Comprehensive Community-Based Children's Mental Health Service Systems

Freedom Commission Goals:

Goal 1: Mental Health is Essential to Health: *Every individual, family and community will understand that mental health is an essential part of overall health.*

Goal 2: Early Mental Health Screening and Treatment in Multiple Settings*: Every individual will have the opportunity for early and appropriate mental health screening, assessment, and referral to treatment.*

Goal 3: Consumer/Family Centered Care: *Consumers and families will have the necessary information and the opportunity to exercise choice over the care decisions that affect them.*

Goal 4: Best Care Science Can Offer: *Adults with serious mental illness and children with serious emotional disturbance will have ready access to the best treatments, services, and supports leading to recovery and cure. Accelerate research to enhance prevention of, recovery from and ultimate discovery of cures for mental illnesses.*

Transformation Activities:
reduction of the stigma associated with mental illness
suicide prevention
improving coordination of care among multiple systems
assuring individualized plans of care for all consumers
development of culturally competent services
aligning financing for mental health services for maximum benefit

Descriptive Information:

The Children's Mental Health Bureau (CMHB) is part of the Department of Health and Human Services (DPHHS). As part of the Health Resources Division (HRD), CMHB is responsible for management of children's mental health services and development of a system of care for youth mental health services. Established in July 2003 as a result of legislative action, CMHB is administered by the state of Montana with oversight by the Children's System of Care Committee and the Mental Health Oversight Advisory Council.

The central CMHB office is housed on the Capital complex and includes administrative, clinical and SAMHSA grant staff. Five regional program officers are placed throughout the state in each administrative region. CMHB staff includes a bureau chief, three clinical officers, and positions for a data analyst and a financial officer. Central office SAMHSA staff include the project director and regional staff supervisor, an evaluator/data analyst, and social marketing/training coordinator. The other SAMHSA grant staff are located in each of the granted sites.

Central office program officers are licensed clinicians responsible for specific Medicaid mental health programs and provide budget management and oversight for these service areas resulting in

cost containment. In addition, they provide clinical oversight to individual youth cases & are primarily responsible for court ordered youth.

The regional program officers are responsible for the development and implementation of the children's mental health system of care in each region. They've become a liaison between the local communities, the state office, First Health, the System of Care Committee, and often the adult Service Area Authorities. Their statewide presence increases the flexibility in facilitation, coordination, and planning of services to SED youth. They are also responsible for approval of CMHSP-Part B requests for supplemental services.

The Department of Public Health and Human Services enters its third year of a six year SAMHSA grant October 1, 2006. The first community grants were awarded in October 2005 to Billings, Missoula and the Crow Nation, our SAMHSA partner. These sites are ending their first year of infrastructure development and moving into year two will begin to offer services to youth and their families. Three additional communities were chosen in the second round of implementation grants in August 2006 -- Helena, Butte, and a northern Montana collaboration between the Fort Belknap Reservation, the Rocky Boy's Reservation and Hill County.

Children's Mental Health Bureau (CMHB) is responsible for management of mental health services from several funding sources: Medicaid, Children's Health Insurance Plan (CHIP) and the Children's Mental Health Service Plan (CMHSP). Children with serious emotional disturbance can access services by one of these plans. Each program has eligibility criteria and limits to their service array.

The 2005 Montana Legislature increased the Medicaid resource limit from $3000 to $15,000 beginning July 1, 2006. The projected increase to Medicaid is 3800 youth, with 3000 moving from the Children's Health Insurance Program (CHIP) to Medicaid. With last year's increase in the number of available slots, CHIP has a capacity to enroll 13,900 youth. Current enrollment is 13,113.

Mental Health

Montana's public mental health system strives to provide a full range of mental health services to children and adolescents with priority on services to youth with serious emotional disturbance. To the greatest extent possible, services are offered in the least restrictive, most appropriate, setting, preferably in the youth's home and community.

Medicaid youth with SED have access to the following mental health services: inpatient psychiatric hospital care and partial hospital care, inpatient psychiatric residential care, therapeutic group and foster care, outpatient mental health services including assessment, individual & family therapy (limited to 24 visits per year), group therapy, school based day treatment, individual or group community-based psychiatric rehabilitation and support services, and targeted youth case management. Some services require prior authorization and periodic review for medical necessity.

Children's Health Insurance Plan (CHIP) covered youth with SED have access to limited mental health services-- individual, family and group therapy (20 sessions per year), 21 days a year partial hospitalization or residential treatment, and unlimited pharmacy. Extended mental health benefits for those youth who qualify include— 30 days of therapeutic group care including room and board, 30

days of moderate level therapeutic family support, 100 hours of Community Based Psychiatric Rehabilitation and Support (CBPRS), 120 hours of day treatment, an SED clinical assessment (that counts as one individual session), and 30 additional individual and/or family visits.

As a result of the tobacco tax increase CHIP will provide extended mental health benefits to eligible SED youth including limited access to therapeutic group care, in-home therapeutic services and additional individual and family therapy. An estimated 265 youth (2.4%) of CHIP youth will qualify for the extended benefits. CHIP and CMHSP income guidelines are set at 150% of poverty. 135 youth are eligible for CMHSP- Part A if they are not eligible for Medicaid or CHIP.

The Children's Mental Health Services Plan (CMHSP) is a capped program at $671,000 providing limited mental health services for eligible youth within 150% of poverty. CMHSP is 100% state general fund dollars. The Children's Mental Health Bureau staff work closely with the CHIP staff to determine eligibility for the CMHSP program and to identify youth who need mental health services-

- CMHSP- Part A includes the following services: community-based outpatient services of individual, group and family therapy, assessment and evaluation, psychotropic medication monitoring and management, and services of a licensed mental health center. CMHSP includes a psychotropic drug formulary up to $425 per month.
- CMHSP-Part B services are supplemental services directed at family preservation either by maintaining the youth in his/her family or returning the youth to parent's care. Part B services are not a covered service under the other above-named plans. Services include room and Board for therapeutic group care and foster care, 1:1 mental health aide services, family therapy, or other services to the family.

Montana currently has four community mental health centers that provide outpatient services in fifty-five of our fifty-six counties. Montana has thirteen licensed mental health centers that serve youth and provide each of the core services as well as one or more of the services typically provided by a community mental health center. In addition to licensed mental health centers, private providers offer treatment for Medicaid eligible youth including outpatient therapy and psychiatric services.

Center for Mental Health (formerly known as Golden Triangle Community Mental Health Center) headquartered in Great Falls - outpatient individual and group therapy; physician and non-physician inpatient consultation; outpatient psychiatric services; transitional living; telephone crisis services; consultation and education; targeted youth case management; family based services; community psychiatric rehabilitation and support; and mobile crisis. Center for Mental Health serves a twelve county area in north central and southwest Montana.

Eastern Montana Community Mental Health Center headquartered in Miles City - outpatient individual and group therapy; non-physician inpatient consultation; transitional living; telephone crisis services; consultation and education; and Department of Public Health and Human Services (DPHHS) approved chemical dependency services. Eastern Montana Community Mental Health Center provides services in the most eastern seventeen counties of Montana.

South Central Regional Mental Health Center headquartered in Billings - outpatient individual and group therapy; physician and non-physician inpatient consultation; outpatient psychiatric services; telephone crisis services; consultation and education; and DPHHS approved chemical

dependency services. South Central Regional Mental Health Center serves twelve counties in south central and southwestern Montana. South Central contracts with Youth Dynamics to provide children mental health services.

Western Montana Community Mental Health Center headquartered in Missoula - outpatient individual and group therapy; physician and non-physician inpatient consultation; outpatient psychiatric services; therapeutic foster care; Comprehensive School and Community Treatment (CSCT); Dialectic Behavior Therapy groups; therapeutic group home in Kalispell; telephone crisis services; mobile crisis worker services; consultation and education; youth targeted case management; community based psychiatric rehabilitation and support; and DPHHS approved chemical dependency. Western Montana Community Mental Health Center serves fifteen western counties in Montana.

Other mental health centers providing services to children and adolescents with serious emotional disturbance are:

Altacare headquartered in Butte- provides outpatient services and Comprehensive School and Community Treatment in 54 schools across the state.

A.W.A.R.E., Inc. headquartered in Anaconda – provides respite care, therapeutic group homes, therapeutic family care, day treatment, Comprehensive School and Community Treatment, community based psychiatric rehabilitation and support, youth targeted case management, and in training practitioners. A.W.A.R.E. offices are located in over twenty-one communities.

Bitterroot Cooperative headquartered in Stevensville – provides Comprehensive School and Community Treatment; respite care and in training practitioners. Services are provided in six communities.

In Care Network, Inc. headquartered in Billings- provides community based psychiatric rehabilitation and support services; targeted youth case management; and therapeutic foster and group care, and upon request training on design and delivery of culturally sensitive services for Native American youth on the Northern Cheyenne and Crow reservations. Services are provided in the Billings area.

Intermountain (formerly known as Intermountain Children's Home & Services) headquartered in Helena- provides therapeutic group care, therapeutic foster care, therapeutic family support, targeted youth case management; day treatment services, and outpatient psychiatric services. Services are provided in Helena and the surrounding communities.

New Day headquartered in Billings- provides therapeutic group care, targeted youth case management, therapeutic foster care, therapeutic family support, and day treatment services. They provide an outdoor adventure program focused on native youth with co-occurring disorders. Services are provided in the Billings area.

Northwest Behavioral Health headquartered in Kalispell- provides outpatient, partial hospitalization, and Comprehensive School and Community Treatment (CSCT). NWBH provides services in the Kalispell area.

Yellowstone Boys and Girls Ranch headquartered in Billings- provides respite care, day treatment, community based psychiatric rehabilitation and support services, Comprehensive School and Community Treatment; therapeutic group home, therapeutic foster care, targeted youth case management, and in training practitioners. They have a trained DBT team. They have services in two communities.

Youth Dynamics headquartered in Billings – provides respite care, community based psychiatric rehabilitation and support services, Comprehensive School and Community Treatment; therapeutic family care, therapeutic group care, targeted youth case management, day treatment, and training for practitioners. Youth Dynamics provides services in twenty-four communities.

As of June 30 2006, ACS (fiscal fiduciary) had paid claims to the following provider types: 58 psychiatrists (in state), 91 psychiatrists (out of state), 161 psychologists, 179 social workers, 422 licensed clinical professional counselors, 1 inpatient psychiatric hospital (for individuals under 21), 3 in state residential treatment centers (RTC), 18 out of state (RTC), 21 therapeutic group home providers, 9 therapeutic foster care agencies, 232 retail pharmacies, 89 hospital or clinic pharmacies, 59 hospitals and 583 physicians are in addition to the centers listed above.

In-patient psychiatric hospital services for youth under 21 are provided by Shodair Children's Hospital, Helena. St. Patrick's Hospital, Missoula; Benefis Health Care in Great Falls; Kalispell Regional Medical Center, Kalispell; and Deaconess Hospital, Billings provide limited inpatient psychiatric services for both children and adults.

Medical/Dental

Children with serious emotional disturbance may access health services through eligibility for Medicaid or CHIP. Those children without insurance or on CMHSP can access public health services through public health clinics and public health nurses that travel to rural communities. Dentists can be accessed through these clinics but there is a tremendous waiting list for such services.

Health

DPHHS has many programs for health services related to youth; Early Periodic Screening Diagnosis and Treatment (EPSDT), adolescent health including suicide prevention, early childhood programs, and early intervention programs. CMHB staff participates on work groups at the state level to collaborate with these sister programs.

Education/Rehabilitation

DPHHS and the Office of Public Instruction have a Memorandum of Understanding to develop appropriate transition plans for those students who have serious emotional disturbance. The education system with cooperation of the parents seeks appropriate services with vocational rehabilitation. A memorandum of understanding between OPI and DPHHS ensures a smooth transition from children's services to adulthood which can include a transition for employment,

education, or adult mental health services. Comprehensive School and Community Treatment (CSCT) programs re-emerged in 2004. A school district- mental health collaborative work closely in determining the most appropriate and least restrictive services for those students with SED in the school system. Services include day treatment, mental health support in classrooms, 1:1 aides for youth, as well as individual and family therapy. Although youth do not have to qualify for special education services to receive mental health services, IDEA and the IEP process play an important role in this collaboration.

Employment

A memorandum of understanding between DPHHS and OPI provides a mechanism for employment for youth who don't finish school. At age 16 those youth are identified by the school. Tumbleweed, an organization working with youth in the foster care system offers support for employment to qualified youth, many of whom have an SED diagnosis. A noted gap in the Montana system is employment opportunities and support for parents of SED youth. When in crisis those youth can disrupt a work schedule and without a sympathetic employer parents can quickly find themselves unemployed.

Housing

Very few shelters in the state accept families and even fewer youth only. The communities of Great Falls, Missoula, Helena and Billings have shelters for youth and/or families. Interfaith Hospitality is a program growing in Bozeman and Billings- a network of churches shelter families for a week at a time providing housing, and food. Tumbleweed, the Chaffee project in Montana, offers housing assistance to youth who are, or have been a part of the foster care system.

Housing for families with SED youth can be challenging. Landlords and neighbors can be intolerant of the behaviors, property damage, and even mental health interventions that are sometimes needed resulting in evictions and/or police reports. This adds strain to an already stressed family system.

Substance Abuse

Addictive and Mental Disabilities Division (AMDD) maintains contracts with chemical dependency programs across the state. Co-occurring disorders are presumed to be the rule, not the exception even with youth. Training of providers has been offered by AMDD. A co-occurring task force meets regularly and includes staff from CMHB.

Targeted Youth Case Management

In July 2006 the state expanded targeted youth case management services to allow these services to be offered by any qualified provider. This replaces the regional provider system that has been in place since 2001. This offers families a choice of case management providers. Targeted youth case management is valued as a 'first line of defense' for SED youth and their families and in its design empowers parents to learn to become advocates for themselves and their youth.

Other support services to assist individuals to function outside of inpatient or residential institutions.

The entire children's system of care is designed to support youth in the community, rather than hospital settings. Those services include but are not limited to: Community Based Psychiatric Rehabilitation and Support (CBPRS), therapeutic family support, therapeutic foster care, respite care, individual and family therapy. All mental health centers must provide clients with access to 24-

hour response. The KMAs work together to ensure youth who can be served in their home communities have the services and supports in place to do so. If placement at home is not possible, therapeutic foster care and therapeutic group care are available.

Activities to Reduce Hospitalization

The Department's utilization review contractor must authorize inpatient hospitalization. Prior authorization is also required for residential treatment, therapeutic family care and therapeutic group care. All remaining services are subject to retrospective review for medical necessity. Plans are underway to include case management and community based psychiatric rehabilitation and support in utilization reviews. KMAs, First Health Regional Care coordinators, and CMHB regional staff work to ensure youth and families have appropriate services at home, and in their home community, if at all possible. They also track youth in out of community placements, especially youth in residential treatment, to ensure plans are in place for a step-down back to the community.

Evidenced Based Practice

Therapeutic Foster Care (TFC) is the only listed evidence based practice currently utilized in Montana. Nine TFC providers offer services across the state. In 2003, therapeutic family support was added to the same code for billing purposes. Therefore, it's impossible to accurately report how many youth are served by each. A work group has been meeting to separate the two programs recognizing they are distinct services; the goal is for them to finish their work in the next several months. Once the services can be billed separately, an accurate count of how many children served will be available.

System of Care Development

Two major goals for Health Resources Division are: to implement the systems of care philosophy at the state and local levels; and plan for, develop and/or enhance a wraparound process that will enable children with serious emotional disturbance and their families to access a broad array of supports and services necessary to meet their unique needs.

Montana is home to seven sovereign Native American nations. The developing system of care is honored to have among our partners- the Crow Nation, Confederated Salish and Kootenai of the Flathead, the Chippewa-Cree of Rocky Boy's, the Assiniboine and Gros Ventre of Fort Belknap. The Blackfeet Reservation was awarded a separate SAMHSA grant and CMHB intends to coordinate closely with them as we both move forward in our system of care development. Sixteen Montana communities are in various stages of local system of care development.

Since 2003 the Children's System of Care has provided statewide leadership in the emerging development of a community-based, youth and family-centered, culturally competent mental health system. Core values guiding this system include:

- Parent/Family participation at all levels of the children's system of care from policy planning to participation in their child's treatment plan.
- Cultural competence requiring agencies, programs and services to be responsive to the needs and culture of the populations served.
- A focus on the strengths of the parents and family as contributors to treatment and recovery.
- "Top-Down-Bottom Up" approach in partnerships with local communities, including our seven sovereign nations to design and develop the system of care.

- Through partnerships with providers design, and deliver evidenced-based services to youth with SED and their families.
- Increase co-occurring capacity to ensure service delivery with an integrated focus on both mental health and chemical dependency treatment needs.

Representatives from the following entities comprise the Committee:

- Parents and Youth
- Native Americans
- Office of Public Instruction
- Mental Health Advocates/Ombudsman
- Service Area Authority (SAA)
- Providers
- Supreme Court (juvenile probation)
- Legislature
- Department of Corrections
- First Health Services of Montana
- Mental Health Oversight Advisory Council
- Department of Public Health and Human Services
  - Children's Mental Health Bureau
  - Chemical Dependency Program
  - Child and Family Services
  - Division Disability Services Program

KMA community teams and the System of Care Committee are charged with identifying gaps in the continuum of care and creating solutions. Montana's rural demographic creates a unique challenge in developing an adequate system of care in a variety of ways. We have seven sovereign tribal nations, each with their own unique culture and traditions. Montana's culture is one of rugged individualism, needing and asking for help and providing adequate levels of funding for mental health comes hard. Other more 'traditional' gaps include: institutional barriers to braided and/or blended funding, training and technical support needs, increasing cultural competence, creating a common 'language' and understanding of the issues and system. Continuing to build on the relationships between the state, communities, providers and families is a high priority and a noted gap in the current paradigm.

The Kids Management Authority provides a framework for agencies to participate in the development of comprehensive plans of care for children at risk of out-of-home placement. These include the education, vocational rehabilitation, state approved alcohol and drug programs, juvenile justice, housing, and First Health regional care coordinators. This is to ensure that needed services are available for the adolescent and his/her family.

KMAs have two distinct and important functions:

- **Community Teams**
  They are tasked with creating a process for a local system of care, identifying and creating ongoing community resources, developing policies and procedures to ensure unified and comprehensive service delivery, and serving as the gateway to the local system.
- **Individual Care Coordination Teams (ICCT)**
  With few exceptions, parents are the leaders of the individual team for their child. The team, comprised of agencies and individuals involved with the youth and their family design a unified and comprehensive treatment plan that encompasses all agencies serving an individual family.

Issues for Montana youth and families:

- stigma of being a person with and/or raising a youth with a mental illness,

- varying commitment for youth and parental involvement in planning for individual services and policy and planning,
- lack of prevention and early intervention services,
- a serious lack of child psychiatrists across the state that are available for publicly-funded youth,
- lack of adequate community based services and payment mechanisms for those services families find most useful,
- services that are sometimes duplicative and not coordinated,
- deficit-based rather than strength-based services, and
- disparity in culturally sensitive services.

Goal One: **Design, implement and support a community-based system of care for youth and their families.**

Indicator One: Strengthen community collaboration and capacity.

Measure: Baseline indicator.
Numerator: Number of attendees at KMAs across the state.

Source: Attendance sheets from local KMAs. Start date is July 1 2006.

Significance: Community stakeholder participation is critical to the success of a community-based system of care. Collaboration and partnership building is the foundation for local system development.

Target:

(1)	(2)	(3)
Fiscal Year	2006 (target)	2007 (target)
Performance Indicator	1536	1920
Numerator	1536	1920

Indicator Two: Identify and/or create funding sources.

Measure: Baseline indicator
Numerator: In-kind and hard matched funds for KMAs.

Source: Invoices and match documents sent to CMHB

Significance: Document local support and begin building for sustainability across time.

Target:

(1)	(2)	(3)	(4)
Federal Fiscal Year	2005 (target)	2006 (target)	2007 (target)
Performance Indicator	$138,750.	$333,000.	$854,250.
Numerator	$138.750.	$333,000.	$854,250.

Indicator Three: Conduct broad-based community assessments at SAMHSA funded sites; profile local gaps, strengths, and assets; and locate and/or establish needed resources within the community.

Measure: 6 of 6 SAMHSA granted communities complete services inventory assessment and gaps analysis in the first year of their individual funding cycle.
Numerator: Number of granted communities completing the tasks
Denominator: Total number of granted communities.

Source: Service inventory assessments and gaps analysis reports provided from the granted communities to CMHB.

Significance: In order to enhance the system of care, we must identify strengths and gaps in service delivery to SED youth and their families at the community level. A primary goal of the system of care is to keep youth at home and in their communities.

Target

(1)	(2)	(3)
Fiscal Year	2006	2007
Performance Indicator	50% (target)	100% (target)
Numerator	3	6
Denominator	6	6

Goal Two: Increase family involvement at all levels of the System of Care.

Indicator One: Of those respondents to the survey, 80% of SED youth and their families receiving community-based services will report they've been involved in their treatment planning.

Measure: Numerator: Number of SED youth and their families who indicate agree or strongly agree they have been involved in their treatment (MHSIP survey questions 15 and 24).
Denominator: Total number of SED youth and their families who receive community based mental health services.

Source of Information: Statewide aggregate data from the Consumer Satisfaction Survey.

Significance: Empowering youth and families to take an active role in treatment increases potential long term success and change.

Target:

(1)	(2)	(3)	(4)	(5)
Fiscal Year	2004	2005(est.)*	2006 (target)	2007 (target)
Performance Indicator	89%	80%	80%	80%
Numerator	66	89	80	80
Denominator	74	90	100	100

Indicator Two: Increase family participation at system development levels: Community KMAs, System of Care Committee and Mental Health Oversight Advisory Council.

Measure: Baseline indicator
Numerator: family member participant
Denominator: total number of participants

Source of Information: Attendance sheets from Mental Health Oversight Advisory Council, System of Care Committee, KMAs and Systems of Care workgroups.

Significance: Family and youth participation is a cornerstone of the system of care empowering families and youth to be equal partners. Having those directly impacted by SED youth at the table changes the conversation, increases the richness of our understanding, and provides belief the system can work.

Target:

(1)	(2)	(3)
Fiscal Year	2006 (target)	2007 (target)
Performance Indicator	20%	30%
Numerator	316	590
Denominator	1584	1968

Goal Three: Integrate a wrap-around philosophy into the service delivery.

Indicator One: Complete comprehensive community service inventory in the six SAMHSA granted sites to identify service gaps and needs.

Measure: 6 of 6 SAMHSA granted communities complete services inventory assessment and gaps analysis in the first year of their individual funding cycle.
Numerator: Number of granted communities completing the tasks
Denominator: Total number of granted communities

Source: Service inventory assessments and gaps analysis reports provided from the granted communities to CMHB.

Significance: Implementing wrap-around services for SED youth and their families must begin with identification of those services families and youth find helpful but are not accessible across the state.

Target:

(1)	(2)	(3)
Fiscal Year	2006	2007
Performance Indicator	50% (target)	100% (target)
Numerator	3	6
Denominator	6	6

Indicator Two: Identify wraparound services inventory in the six granted communities based on community services inventories.

Measure: Baseline indicator
Numerator: Services indicated as lacking in the community services inventories.
Denominator: All services identified in the services inventory.

Source of Information: Community services inventory

Significance: Providing a wider array of appropriate community wrap-around services decreases the need for higher levels of care.

Target:

(1)	(2)	(3)
Fiscal Year	2006	2007
Performance Indicator	*Pending	Pending
Numerator	Pending	Pending
Denominator	Pending	Pending

* Estimating targets will be performed after community services inventory is complete.

Indicator Three: Use of flexible funding to provide non-traditional services to SED youth and their families.

Measure: The amount of money spent on flexible services.

Numerator: Amount of dollars spent in each granted community for non-traditional services.

Significance: Non-traditional and creative mental health services increase positive outcomes and will increase the likelihood that SED youth will remain with their families and in their communities.

Source: Financial reports submitted by the grant sites.

Target:

(1)	(2)	(3)
Fiscal Year	2006	2007
Performance Indicator	$90,000* (est.)	$120,000* (est.)
Numerator	$90,000* (est.)	$120,000* (est.)

* estimate is dependent upon approval of the SOC committee

Indicator Four**:** To reduce the percentage publicly funded inpatient psychiatric residential treatment facility placements in out-of-state facilities by 25% in SFY2007.

Measure: Numerator: The number of youth (unduplicated count) placed into out-of-state inpatient psychiatric residential facilities during SFY 2007.
Denominator: The total number of youth under 18 years (unduplicated count) of age placed under Medicaid funding into inpatient psychiatric residential treatment during SFY 2007.

Source of Information: Montana MMIS database.

Significance: The closer a youth is to his/her family; the more likely the family is able to participate in treatment, the shorter the length of stay and the higher potential for family reunification.

Target:

(1)	(2)	(3)	(4)
Fiscal Year	2005	2006	2007 (target)
Performance Indicator	7%	18%	14%
Numerator	36	96	
Denominator	469	509	

Indicator Five: Maintain/stabilize the overall residential treatment center population to 5%.

Measure: Numerator: The number of youth (unduplicated count) placed into in and out-of-state inpatient psychiatric residential facilities during SFY 2006.
Denominator: The total number of SED Medicaid youth under 18 years (unduplicated count) of age during SFY 2006.

Source of Information: Montana MMIS database.

Significance: Treating SED youth in or near their home communities increases chance for successful outcomes and reduces the high cost of hospital care.

Target:

(1)	(2)	(3)	(4)
Fiscal Year	2005	2006	2007 (target)
Performance Indicator	5%	5%	10%
Numerator	469	509	
Denominator	9480	9551	

Indicator Six: Decrease the rate of children discharged from residential treatment who is readmitted within 30 days.

Measure: Numerator: Number of children readmitted to residential treatment within 30 days.
Denominator: Total number of residential discharges.

Source of Information: Admission/discharge data from residential treatment centers.

Significance: Rapid recidivism may reflect ineffective or inadequate community services or support/education to the family, very serious emotional disturbance, premature discharge or noncompliance.

Target:

(1)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2004 Actual	FY 2005 Actual	FY 2006 Target	FY 2007 Target
Performance Indicator	9.28%	7.6%	7%	6%
Numerator	41	34	n/a	n/a
Denominator	442	449	n/a	n/a

Indicator Seven: Decrease the percentage of children discharged from residential treatment readmitted within 180 days.

Measure: Numerator: Number of children readmitted to residential treatment within 180 days.
Denominator: Total number of residential discharges.

Source of Information: Admission/discharge data from residential treatment centers.

Significance: Rapid recidivism may reflect ineffective or inadequate community services or support/education to the family, very serious emotional disturbance, premature discharge or noncompliance.

Target:

(1)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2004 Actual	FY 2005 Target	FY 2006 Target	FY 2007 Target
Performance Indicator	2.3%	2.2%	2%	2%
Numerator	10	10	n/a	n/a
Denominator	442	449	n/a	n/a

Goal Four: **Ensure respectful and culturally competent services within the system of care.**

Indicator One: 65% of the children with SED and their families who receive case management services under Medicaid will report overall positive outcomes for their family.

Measure: Numerator: The number of respondents who answer "Agree" or "Strongly Agree", to #1 survey.
Denominator: The number of respondents to the survey.

Source of Information: Statewide aggregated data from the Consumer Satisfaction Survey. 1975 surveys were mailed in 2005 without stamped return envelopes significantly decreasing the response rate.

Significance: Effective case management services allow parents to increase self management skills and self reliance, enhance or attain self advocacy skills, develop networking capacity, and reduces stigma for families and in communities.

Target:

(1)	(3)	(4)	(5)	(6)
Fiscal Year	2004	2005	2006	2007
Performance Indicator	72 %	70%	70% (Target)	70% (Target)
Numerator	54	63		
Denominator	74	224		

Indicator Two: 70% of families respond that the services they received were respectful of their individual or family's culture.

Measure: Numerator: Number of respondents who respond "agree or "strongly agree" to questions 25, 27, 29 of the Consumer Satisfaction Survey.

Denominator: Total number of respondents on questions 25, 27, & 29.

Source of Information: Statewide aggregated data from the Consumer Satisfaction Survey. 1975 surveys were mailed in 2005 without stamped return envelopes significantly decreasing the response rate.

Significance: Respectful treatment of families increases their investment in the process and the system; furthers the goals of system of care by respecting individual families.

Target:

(1)	(3)	(4)	(5)	(6)
Fiscal Year	2004	2005	2006	2007
Performance Indicator	90%	78%	70% (Target)	70% (Target)
Numerator	67	174		
Denominator	74	224		

Indicator Three: Increase the number of KMA participants that have had cultural training in the past year.

Measure: Baseline indicator
Numerator: Number of KMA, and SOC members who report they have participated in cultural competency training in SFY2007.

Source of Information: Self report by KMA and SOC membership.

Significance: Cultural competence is central to improving outcomes and respecting family values as well as culture.

Indicator Four: 80% of children with SED and their families who receive community-based services including targeted case management services will report a high cultural sensitivity of staff delivering services.

Measure: Numerator: Number of respondents who respond "agree or "strongly agree" to question 29 of the Consumer Satisfaction Survey.

Denominator: total number of respondents on questions 29.

Source of Information: Statewide aggregated data from the Consumer Satisfaction Survey. 1975 surveys were mailed in 2005 without stamped return envelopes significantly decreasing the response rate.

Significance: Families who are respected have a higher potential for success.

Target

(1)	(3)	(4)	(5)	(6)
Fiscal Year	2004	2005	2006 (target)	2007 (target)
Performance Indicator	85.1%	85%	80%	80%
Numerator	63	190		
Denominator	74	224		

Indicator Five: Children with SED and their families who receive community-based mental health services and are surveyed will report a positive perception of access to services.

Measure: Numerator: Number of respondents who respond "agree or "strongly agree" to questions 16, 17, 19, and 20 of the Consumer Satisfaction Survey.

Denominator: Total number of respondents on questions 16, 17, 19, and 20.

Source of Information: Statewide aggregated data from the Consumer Satisfaction Survey. 1975 surveys were mailed in 2006 without stamped return envelopes significantly decreasing the response rate.

Significance: Access to services creates potential for success for youth and their families and can prevent migration to higher levels of care.

Target:

(1)	(2)	(3)	(4)	(5)
Fiscal Year	2004	2005	2006	2007
Performance Indicator	83.8%	75%	84%	84.4%
Numerator	62	168		
Denominator	74	224		

CRITERION 2: Mental Health System Data Epidemiology

Freedom Commission:

Goal 3: Consumer/Family Centered Care: *Consumers and families will have the necessary information and the opportunity to exercise choice over the care decisions that affect them.*

Transformation Activities: *assuring individualized plans of care for all consumers*
removing disparities in access to and quality of care

Descriptive Information:

Montana is proud of the variety of mental health services available to SED youth and their families. In July 2006, targeted youth case management reverted to a previous system allowing all qualified providers to offer case management wherever they choose. The previous system divided the state with one case management entity per administrative region. This change allows family choice of case management providers. In many communities there is a choice of provider for other community

based services as well. However, in the most rural areas access to service and choice are severely limited.

The 2005 Montana Legislature appropriated $2,987,368 ($2,112,368 of Medicaid funds and $875,000 state special funding generated by the Tobacco Tax) to support a direct care worker wage increase to be distributed during the 2006-2007 biennium. The intent of the legislation was to increase wages for the lowest paid staff working who spend at least 75% of their time working directly with youth. By definition, direct care staff provides Community Based Psychiatric Rehabilitative & Support Services (CBPRS), Youth Day Treatment services, Therapeutic Group Home services, Residential Treatment Center services, and Therapeutic Family Care services. Youth Case Management services did not meet this definition.

The Department of Public Health and Human Services, Health Resources Division's Children's Mental Health Bureau uses the serious emotional disturbance (SED) definition, applied a prevalence of 7.6% based on WICHE Mental Health Program published April 2006. When applied against Montana's children's population the estimated number of SED youth is approximately 17,424.

SED Definition:

FOR CHILDREN AGE 6 – 17

Must meet *one* of the following within the last 12 months as diagnosed by licensed mental health professional (must be moderate/severe):					
	i.	Childhood schizophrenia (295.10, 295.20, 295.30, 295.60, 295.90)		**xi.**	Dysthymic disorder (300.4)
	ii.	Oppositional defiant disorder (313.81)		**xii.**	Cyclothymic disorder (301.13)
	iii.	Autistic disorder (299.00)		**xiii.**	Generalized anxiety disorder (300.02)
	iv.	Pervasive development disorder NOS (299.80)		**xiv.**	Posttraumatic stress disorder (chronic) (309.81)
	v.	Asperger's disorder (299.80)		**xv.**	Dissociative identity disorder (300.14)
	vi.	Separation anxiety disorder (309.21)		**xvi.**	Sexual and gender identity disorder (302.2, 302.3, 302.4, 302.6, 302.82, 302.83, 302.84, 302.85, 302.89)
	vii.	Reactive attachment disorder of infancy or early childhood (313.89)		**xvii.**	Anorexia nervosa (severe) (307.1)
	viii.	Schizo affective disorder (295.70)		**xviii.**	Bulimia nervosa (severe) (307.51)
	ix.	Mood disorder (296.0x, 296.2x, 296.3x, 296.4x, 296.5x, 296.6x, 296.7, 296.80, 296.89)		**xix.**	Intermittent explosive disorder (312.34)
	x.	Obsessive-compulsive disorder (300.3)		**xx.**	Attention deficit/hyperactivity disorder (314.00, 314.01, 314.9) when accompanied by at least one of the diagnoses listed above

AND (Must meet *one* of the following):			
	1.	As a result of the diagnosis determined above, must consistently and persistently demonstrate behavioral abnormality in *two or more* of the following for a period of at least *six months* that cannot be attributed to intellectual, sensory or health factors:	
		i.	Has failed to establish or maintain developmental and culturally appropriate relationships with adult caregivers or authority figures
		ii.	Has failed to demonstrate or maintain developmentally and culturally appropriate peer relationships
		iii.	Has failed to demonstrate a developmentally appropriate range and expression of emotion or mood
		iv.	Has displayed disruptive behavior sufficient to lead to isolation in or from school, home, therapeutic or recreation setting
		v.	Has displayed behavior that is seriously detrimental to the youth's growth development, safety or welfare, or to the safety or welfare of others

		vi.	Has displayed behavior resulting in substantial documented disruption to the family including, but not limited to, adverse impact on the ability of family members to secure or maintain gainful employment
or	**2.**	In addition to mental health services, must demonstrate a need for specialized services from at least *one* of the following during the previous *six months*:	
		i.	Education services, due to the diagnosis determined above, as evidenced by identification as a child with a disability as defined in 20-7-401(4), MCA with respect to which the youth is currently receiving special education services
		ii.	Child protective services as evidenced by temporary investigative authority, or temporary or permanent legal custody
		iii.	The juvenile correctional system, due to the diagnosis above, as evidenced by a youth court consent adjustment or consent decree or youth court adjudication
		iv.	Current alcohol/drug abuse or addiction services as evidenced by participation in treatment through a state-approved program or with a certified chemical dependency counselor

FOR CHILDREN AGE 0 – 5

Must exhibit *one or more* of the following for at least *six months* (or is predicted to continue for at least 6 months) which cannot be attributed to intellectual, sensory or health factors and results in substantial impairment in functioning:		
	i.	Atypical, disruptive or dangerous behavior which is aggressive or self-injurious
	ii.	Atypical emotional response which interfere with the child's functioning, such as an inability to communicate emotional needs and to tolerate normal frustrations
	iii.	Atypical thinking patterns which, considering age and developmental expectations, are bizarre, violent or hypersexual
	iv.	Lack of positive interests in adults and peers or a failure to initiate or respond to most social interaction
	v.	Indiscriminate sociability (e.g., excessive familiarity with strangers) that results in a risk of personal safety of the child
	vi.	Inappropriate and extreme fearfulness or other distress which does not respond to comfort by caregivers

Goal One: **To provide medically necessary mental health services to eligible children and adolescents who have Serious Emotional Disturbance (SED).**

Indicator One**:** Maintain an array of community based services for children and adolescents with SED.

Measure: Numerator: Number of community based services available to SED youth.

Source of Information: MMIS database

Significance: Offering an array of services available to SED youth and their families creates opportunities for community-based treatment.

Medicaid Mental Health Services
Recipients by Service and Paid Claims

Services	FY 05 Individuals	FY 06 Individuals	FY 05 Net Payments	FY 06 Net Payments
Community Mental Health	2020	2012	$4,441,781	$4,440,531
Direct Care Wage Increase				$1,069,383
Federally Qualified Health	377	419	$105,883	$150,738
Inpatient Hospital	412	451	$1,953,915	$3,679,544

Lab & X-Ray	101	141	$6,014	$8,362
Licensed Professional Counselors	4374	4364	$2,487,700	$2,577,192
Mid Level Practitioners	907	998	$184,302	$231,653
Outpatient Hospital	1875	1876	$1,406,043	$1,625,663
Personal Care	29	34	$164,407	$153,923
Physicians	3302	3240	$368,973	$428,197
Psychiatrists	2279	2555	$1,106,647	$1,789,763
Psychologists	979	1007	$423,618	$489,273
Residential Treatment	452	465	$14,392,332	$16,777,330
Rural Health Clinics	324	363	$85,697	$116,144
School Based Services	3598	3747	$7,756,019	$10,150,290
Social Workers	1949	1859	$949,313	$894,485
Targeted Youth Case Management	3256	3456	$4,633,813	$5,192,170
Therapeutic Foster Care	879	750	$5,039,101	$4,981,070
Therapeutic Group Care	531	502	$14,609,237	$15,133,651
TOTAL			$60,114,795	$69,889,362

*Providers have 365 days to submit a claim for services rendered.

All of the expenditures for these services may not be reflected.

Children's Mental Health Services Plan
Recipients by Service and Paid Claims

Services	FY 05 Individuals	FY 06 Individuals	FY 05 Net Payments	FY 06 Net Payments
Community Mental Health	9	0	$921	$0
Outpatient Hospital	0	0	$0	
Licensed Professional Counselors	64	31	$4,278	$2,912
Physicians		1	$4,766	$2,436
Rural Health Clinic		1		$111
Psychiatrists	1	7	$76	$446
Psychologists	0	1	$0	$101
Drug	27	28	$15,816	$9,275
Social Workers	29	29	$2,099	$2,589
Mid Level Practitioner	1	1	$535	$839
Respite	595	607	$323,668	$353,514
Total			$352,159	$372,223

CRITERION 3: Children's Services

Freedom Commission:

***Goal 1: Mental Health is Essential to Health**: Every individual, family and community will understand that mental health is an essential part of overall health.*

***Goal 2: Early Mental Health Screening and Treatment in Multiple Settings**: Every individual will have the opportunity for early and appropriate mental health screening, assessment, and referral to treatment.*

***Goal 4: Best Care Science Can Offer:** Adults with serious mental illness and children with serious emotional disturbance will have ready access to the best treatments, services, and supports leading to recovery and cure. Accelerate research to enhance prevention of, recovery from and ultimate discovery of cures for mental illnesses.*

***Goal 5: Information Infrastructure:** The mental health system will develop and expand its information infrastructure. That infrastructure has many purposes.*

Transformation Activities:

reduction of the stigma associated with mental illness
suicide prevention
linking mental health care with primary care
improving coordination of care among multiple systems
assuring individualized plans of care for all consumers
facilitating consumers' access to public education & affordable housing
provision of Evidence Based Practices

Descriptive Information:

Children's mental health services were separated from the adult system in July 2003, creating the Children's Mental Health Bureau. With partners at the local and state level (Kids Management Authority and System of Care Committee respectively) a comprehensive, community based service delivery system is being implemented. Services for SED youth who have co-occurring disorder, and those with other multi-agency needs serve as the highest priority target population. Parents, youth, caregivers, and families are the heart of this system- a fundamental shift from traditional service delivery systems.

Description of the children's mental health system is contained in Criterion One as are the targets for each of the Goals and Indicators. Please refer to Criterion One for a full discussion of children's activities. The Children's Mental Health Bureau manages not only Medicaid and CMHSP but also assists CHIP in assessment of their extended mental health benefits.

Meaningful collaboration is a cornerstone of this system and exists to some degree at all levels- within the Department of Public Health and Human Services, among the System of Care Committee (SOC), between the SOC and state and SOC and their local communities. Regional program officers are responsible for community collaboration in communities and across Regions; with SAMHSA granted sites and with those non-funded communities.

SOC current membership include: Four parents, four advocates for youth and families, four providers of children's mental health services, three Native Americans, eight state agency representatives, and three other office holders (judges, community representatives).

State collaboration teams include the Early Childhood Collaboration, Connecting for Kids, Comprehensive School and Community Treatment, EPSDT, and Transition Work Group. State level personnel from Developmental Disabilities Division, Adult Mental Health, Child and Family services, First Health Inc., of Montana, Early Head Start Collaboration, Court Services, Department of Corrections, and Tribal Nations participate in committee and work groups to reduce duplication and increase responsiveness to youth and families.

Currently 16 communities across the state are in various stages of KMA development. Six communities have been awarded SAMHSA implementation grants: our partner the Crow Nation, Billings, Missoula, Helena, Havre and the surrounding area, and Butte. Other communities with KMAs are Bozeman, the Deer Lodge Valley, Miles City, Glendive/Sydney, Lame Deer, Wolf Point/Glasgow, Polson, Kalispell, Great Falls, and Lewistown. The Polson KMA has a formal agreement with the Confederated Salish and Kootenai tribes in western Montana. The Havre implementation grant is a collaborative between Hill County, the Rocky Boy's and Fort Belknap Reservations. Regional program officers are an integral force in each of these community teams.

Social Services: The Children's Mental Health Bureau collaborates with the Child and Family Services Division (CFSD). Many times both agencies share the family and child. Both share a goal of family preservation and community-based treatment. Historically CFSD placed youth to facilitate payment for higher levels of care. Although that is no longer true, many facets of the community look to CFSD to 'rescue' the child and family. The local community social service agency is a member of the KMA. A representative of the CFSD is a member of the SOC Committee.

Juvenile Justice: The juvenile justice system often becomes the first agency to intervene with youth that are experiencing a crisis. This agency is a priority in the CMHB collaboration efforts. The local juvenile justice agency is a partner in the KMA. A representative from state juvenile justice is a member of the SOC Committee.

Substance Abuse Services: All contracts with the state approved alcohol and drug programs are required to have an agreement with the mental health centers in their local communities. In addition, there are substance abuse programs that address the co-occurring issues (substance abuse and SED) in their youth treatment programs. Co-Occurring Disorders are considered an expectation not an exception in Montana. The Bureau Chief for the Chemical Dependency Services, Addictive and Mental Disorders Division is an active member of the SOC Committee. Local substance abuse agencies are members of the KMA.

Individuals with Disabilities Education Act (IDEA): The Office of Public Instruction (OPI) is responsible for the educational system in Montana. DPHHS and the Office of Public Instruction collaboratively reinstituted the Comprehensive School and Community Treatment (CSCT) program. The schools and mental health centers collaborate closely in determining the most appropriate and least restrictive services for those students with SED in the school system. These include day treatment and comprehensive school and community services. IDEA and the IEP play an important role in this collaboration. The school districts participate in the KMA. An OPI representative participates in the SOC Committee

First Health, Inc. of Montana, utilization review contractor, has five regional care coordinators across the state. These coordinators partner with Children's Mental Health Bureau regional program officers to encourage local solutions rather than refer to higher levels of care, to encourage step-down from higher levels of care and the earliest, clinically appropriate time, and to enhance the development of KMAs. The regional care coordinators are familiar with community resources and agencies and ensure only those youth who cannot be safely or appropriately treated in their home community are referred to out of home placements. They are often the catalyst for communities to look locally for services for difficult to serve youth and their families.

The State of Montana has applied for a HIFA waiver. If approved this waiver will provide services to youth transitioning out of the children's mental system who do not qualify under serious disabling mental illness (SDMI).

The SAMHSA grant requires participation in regional and national conferences related to system of care. Meetings have afforded the Montana delegation to network and collaborate with existing system of care sites across the nation, learn from those who have gone before, and connect with our Federal partners.

Goal One:	**Provide a seamless transition from children's mental health services to the adult mental health services system for those individuals who meet the criteria.**
Indicator One:	Identify percentage of youth at age 16 who are SED eligible and also meet the diagnostic criteria for SDMI.
Measure:	Baseline Indicator Numerator: Number of youth identified Denominator: All 16 year old SED youth
Source of Information:	MMIS database
Significance:	Begin the process of identifying youth who will transition out of the children's system in the next years.
Target:	Unknown at this time. Will have data next year.
Indicator Two:	Use data gathered as agenda items on work groups and SOC to discuss a process for transitioning youth.
Measure:	Baseline Indicator Numerator: Number of times transition youth appears on agendas.
Source of Information:	Meeting minutes and agendas
Significance:	Document the discussion and importance of addressing the needs of youth who are aging out of the children's system.

Target:	Unknown at this time. Will have data next year.
Goal Two:	**Ensure youth with co-occurring disorders receive integrated services.**
Indicator One:	Maintain written agreements with CD programs.
Measure:	Numerator: Number of agreements
Source of Information:	AMDD records.
Significance:	Document compliance and ensure youth with co-occurring disorders have their needs adequately addressed.
Target:	Unknown at this time. Will have data next year.
Indicator Two:	Participate in co-occurring initiatives.
Measure:	Children's Mental Health Bureau staff attends 90% of the scheduled meetings, trainings, and work groups.
Source of Information:	Co-occurring meeting attendance sheets.
Significance:	CMHB staff reminds all players the significance of addressing the needs of youth with co-occurring disorders.
Target:	Unknown at this time. Will have data next year.
Indicator Three:	Assess co-occurring capability in the six granted sites.
Measure:	Baseline Indicator Numerator: Number of grant sites completing the co-occurring section of the community services inventory.
Source of Information:	Community Services Inventory
Significance:	Creates a baseline for development of co-occurring initiatives by community.
Target:	Unknown at this time. Will have data next year.
Goal Three:	**Integrate services for children and adolescents with Serious Emotional Disturbance who impact multiple agencies in the community**.

Indicator One:	The System of Care (SOC) committee will meet a minimum of four times during SFY 2007.
Measure:	Numerator: Number of time SOC meets in SFY 2007.
Source of Information:	Minutes from the SOC's committee meetings.
Significance:	The SOC committee has legislative directive to provide leadership to the System of Care.
Target:	Unknown at this time. Will have data next year.
Indicator Two**:**	Maintain contract requirement for agreement between mental health provider and the substance abuse provider.
Measure:	Numerator: The number of state approved chemical dependency programs under contract with the Department's AMDD Chemical Dependency
Source of Information:	Chemical Dependency Bureau contract with provider.
Significance:	Assures compliance with state regulation regarding chemical dependency and allows for dialogue for SED youth with co-occurring disorders.
Indicator Three:	CMHB program officers participate in individual and community team meetings for multi-agency youth.
Measure:	Baseline Indicator Numerator: Number of team meetings attended.
Source of Information:	Calendar records of appropriate meetings and self report.
Significance:	Further the goals of system of care and provides highest potential for success for the youth and the communities.

CRITERION 4: Targeted Services to Rural and Homeless Populations

Freedom Commission:

Goal 1: Mental Health is Essential to Health*: Every individual, family and community will understand that mental health is an essential part of overall health.*

Goal 3: Consumer/Family Centered Care: *Consumers and families will have the necessary information and the opportunity to exercise choice over the care decisions that affect them.*

Transformation activities: *reduction of the stigma associated with mental illness*

linking mental health care with primary care
facilitating access to and quality of care
improving coordination of care among multiple systems
development of culturally competent services

Descriptive Information:

For planning mental health services, Montana is an entirely rural state and its mental health system is a rural mental health system. The extent to which this mental health system serves Montana's huge geographic area is impressive. The public mental health system provides professional mental health services in counties with as few as 1.66 people per square mile (Beaverhead County), and part-time professional mental health services in 26 counties with as few as 0.27 people per square mile (Garfield County).

The Eastern Montana Telemedicine Network has been operating since 1993. Telemedicine ensures a continuum of mental health care throughout Eastern and Central Montana. Nineteen sites in Montana and two in Wyoming benefit from their services. Their regional mental health professionals have embraced this program and integrated its use into their care delivery system. Mental health services provided include: medication review, follow-up visits to monitor patient progress, discharge planning, individual and family therapy, emergency consultation, patient care conferences and Employee Assistance Program.

Children's Mental Health staff participated in the Governor's Council on Homelessness and attended the Policy Academy in 2005. There is no current mechanism to locate or monitor SED youth who are homeless. In the next year we'll collaborate with AMDD who has the PATH program in many parts of the state, to begin the dialogue on these fragile youth and their families. Youth who transition out of the children's system but not into the adult system are suspected to be among the homeless in Montana.

Goal One:	**Collaborate with AMDD track homeless children in Montana.**
Indicator One:	Assess number of homeless children in PATH programs.
	Measure: Numerator: Number of youth identified by PATH.
Source of Information:	PATH.
Significance:	Begins the process of identifying the number of homeless youth in Montana.
Indicator Two:	PATH will identify a tracking tool.
Measure:	Numerator: Tracking tool updated.
Source of Information:	Tracking tool

Significance: Begin to collect data, to understand and analyze impact of homelessness on SED youth and provide guidance for services needed.

Indicator Three: Participate with AMDD and PATH providers in a quarterly meeting.

Measure: Numerator: The number of meetings CMHB staff participated in.
Denominator: Total number of meetings.

Source of Information: PATH meeting attendance sheets.

Significance: Collaboration with PATH will increase understanding.

Indicator Three: Identify the number of homeless families with children.

Measure: Numerator: the number of homeless families with children.
Denominator: total number of homeless families

Source of Information: Point in Time survey

Significance: Begins the process of tracking homeless youth.

Target:

Part 1: Homeless Population	**Sheltered**		**Unsheltered**	**Total**
	Emergency	**Transitional**		
# of Families with Children (Family Households):	64	66	15	145
1. # of Persons in Families with Children:	221	196	42	459
2. # of Single Individuals & Persons in Households without Children:	283	179	410	872
(Add Lines Numbered 1 & 2) Total Persons:	504	375	452	1331

CRITERION 5: Management Systems

Freedom Commission:

***Goal 2: Early Mental Health Screening and Treatment in Multiple Settings**: Every individual will have the opportunity for early and appropriate mental health screening, assessment, and referral to treatment.*

***Goal 5: Information Infrastructure:** The mental health system will develop and expand its information infrastructure. That infrastructure has many purposes:*

***Goal 6: Eliminate disparities in mental healthcare:** promote well-being for all people regardless of race, ethnicity, language, place of residence, or age and ensure equity of access, delivery of services, and improvement of outcomes for all communities.*

Transformation Activities: reduction of the stigma associated with mental illness

development of culturally competent services
facilitating consumers' access to employment and affordable housing
aligning financing for mental health services for maximum benefit.
facilitating consumers' access to employment and affordable housing

Descriptive Information:

Efforts to attract qualified professionals to work in Montana's public mental health system are continuing. A practicum in psychiatric nursing at the State Hospital is available for nursing students, as are internships and field placements for students in psychology, counseling, and recreation therapy. Additionally, CMHCs provide opportunities for the establishment of student field placements and in training practitioners. These experiences are aimed at helping future professionals understand the needs youth with serious emotional disturbance and their families. Taking advantage of loan forgiveness incentives associated with working in Health Professional Shortage Areas also assists in recruitment. Montana has only a small percentage of psychiatrists taking advantage of this program. APRNs are allowed to prescribe medications alleviating some of the burden on psychiatrists.

The children's system continues to experience a crisis with limited access to psychiatrists state-wide. In the 17 counties of Region I of Eastern Montana there are no psychiatrists. Shodair Children's Hospital has six child psychiatrists on staff but only those youth hospitalized at Shodair have access to their services. The strain of on-call has curtailed outpatient psychiatric services in many Montana communities making the emergency room the only option for crisis services.

Children's Mental Health Bureau staff includes a bureau chief, three clinical officers, and positions for a data analyst and a financial officer. Central office also includes SAMHSA staff- the project director and regional staff supervisor, an evaluator/data analyst, and social marketing/training coordinator. The other SAMHSA grant staff are located in each of the granted sites. Five regional program officers are located in each state administrative region.

CMHB is actively involved with state and local community training relating to the implementation of the Systems of Care. Each community determines the training they feel is necessary and the Bureau supports those efforts directly with training and technical assistance, and indirectly by passing on information and directing KMAs to other resources. Across the state a number of parent advocacy organizations offer training support and technical assistance to families and KMAs.

These efforts encourage cooperation and coordination of services among the many different components of the State's mental health system.

The block grant is not used to support children's mental health services as a legislative decision resulted in the limited amount of block grant being wholly used to support adult mental health services. TANF (Temporary Assistance for Needy Families) maintenance of effort funds (state general funds) in the amount of $671,928 are used to fund the limited Children's Mental Health Service Plan (CMHSP). These funds are used to purchase community-based services for SED youth. The Children's Mental Health Bureau staff work closely with the CHIP staff to determine eligibility for the CMHSP program and to identify youth who need mental health services.

Additionally Part B of the program provides supplemental mental health services to youth in group homes, foster care along with family services to enhance the opportunity for the child to return home or to step down to a less restrictive treatment environment.

Helena sent a team to Memphis for the 40-hour Community Intervention Team (CIT) training. This team has provided training to law enforcement officers in Montana. The law enforcement agencies in Helena have provided a great deal of support for implementation of CIT in the community. The biggest obstacle for full implementation has been the lack of crisis services beyond the emergency room of the community hospital.

Goal One:	**To offer training at a community level to emergency services personnel.**
Indicator One**:**	Law Enforcement trained in the CIT model.
Measure:	Number of officers trained in SFY2007
Source of Information:	Law Enforcement Academy and NAMI- Helena
Significance:	Although CIT is specific to adults, trained law enforcement officials will be better prepared to deal with all crises, including youth and families.
Indicator Two**:**	Discuss potential training opportunities with juvenile justice personnel.
Measure:	Baseline Indicator Numerator: SOC meeting agenda item to address juvenile justice issues twice during the next year.
Source of Information:	SOC minutes
Significance:	Furthers the goal of an integrated system where all have access to the same, pertinent information
Goal Two:	**To ensure parent, youth and family member participation in state sponsored trainings through Systems of Care.**
Indicator One**:**	Number of parents, youth who participate in state sponsored system of care, and KMA training.
Measure:	Baseline indicator Numerator: number of parents and youth who participate.
Source of Information:	Attendance sheets for all state sponsored trainings.

Significance:	Training and the experience are enriched by all when youth and parents attend.
Indicator Two**:**	Offer financial aid to parents and youth to participate in state sponsored training decreasing barriers to participation
Measure:	Baseline Indicator Numerator: The number of parents and youth who utilize honorariums
Source of Information:	Records from the fiscal bureau detailing reimbursement for parent and youth participation.
Significance:	Increasing parent and youth involvement furthers the goals of the system of care.
Indicator Three**:**	Have regular contact with the Mental Health Ombudsman Office.
Measure:	Baseline Indicator Numerator: The number meetings held with Mental Health Ombudsman during the fiscal year.
Source of Information:	Calendar record of meetings.
Significance:	Information from the Ombudsman's office is critical to understanding the issues families and youth face in the mental health system, identifies barriers to care and access.
Goal Three:	**To offer education to parents, youth and families.**
Indicator One**:**	Create informational brochure which is available state-wide to discuss the systems of care and available services to families.
Measure:	Baseline (one time) Indicator Numerator: Completed brochures
Source of Information:	The printed materials.
Significance:	Access to information increases the potential for discussion, access to care, and further supports the system of care.
Indicator Two**:**	Participate in NAMI-MT annual conference
Measure:	Baseline Indicator Numerator: The number of parents and youth attending the NAMI-MT conference.

Source of Information:	Records of attendance.
Significance:	Access to information increases the potential for discussion, access to care, and further supports the system of care.
Indicator Three:	Access parent trainers to participate in state-sponsored training.
Measure:	Baseline Indicator Numerator: Number of parents and youth utilized as co-trainers
Source of Information:	State-sponsored agendas listing parents and youth as trainers.
Significance:	Parents and youth as trainers provide a unique personal perspective, and furthers system of care goals by having them at each level of the system.
Indicator Four:	50% of Montana's representation at the SAMHSA regional and national meetings are parents or youth.
Measure:	Numerator: Number of parents and youth who attend SAMHSA. Denominator: Total number of Montana participants.
Source of Information:	Registration records of meetings.
Significance:	Parents and youth are central to the success of the system of care. Their participation at all levels enhances the conversation, keeps in focus the reason for system development.
Goal Four:	**To encourage provider training.**
Indicator One**:**	State sponsored training to providers and local communities.
Measure:	Baseline Indicator Numerator: The number of trainings the Children's Mental Health Bureau sponsors.
Source of Information:	Attendance sheets from the trainings.
Significance:	Service providers who understand & support the system of care can better serve youth and families.
Indicator Two**:**	Participate as panel members and speakers when requested.
Measure:	Baseline Indicator Numerator: Number of events CMHB staff participate in as presenters.

Source of Information:	Self report by staff of participation and travel records.
Significance:	The more often system of care goals and principles can be discussed, the more integrated the system will become.
Goal Five:	**Continue the children's set aside for youth and adolescent services.**
Indicator One**:**	A total of $671,928 TANF Maintenance of Effort will be expended for approved services.
Measure:	Numerator: Dollar amount spent. Denominator: Total amount of the TANF MOE.
Source of Information:	Fiscal Bureau records.
Significance:	Additional resources to children and families that support their needs.